Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $8,145.50 for dates of service, 07/09/01 and extending through 08/17/01.

   b. The request was received on 07/09/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. HCFA(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Example EOBs from other Carriers
   f. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Per Rule 133.307 (g) (4), the Division forwarded a copy of the requestor's additional documentation to the carrier on 08/16/02. The respondent did not respond to the additional documentation. The "No Response Submitted" sheet is reflected in Exhibit II of the Commission's case file.

3. Notice of Letter Requesting Additional Information is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 07/23/02
   "…For these services, (Provider) billed $14,737.50, of which $6,592.00 has been reimbursed by the (Carrier). This leaves a disputed balance of $8,145.50….The relevant issue involves (Carrier's) contention that the amount they reimbursed (Provider) for the services provided is reasonable. (Provider) billed at a rate of $150.00 per hour for multidisciplinary, chronic pain management services. The rate reimbursed by (Carrier) was considerable [sic] less. It is (Provider's) assertion that the amount reimbursed is not reasonable, and, in fact, is considerably less than the standard level of reimbursement established in the State of Texas for such services. (Provider) disagrees that this is a reasonable rate of reimbursement for a multidisciplinary, chronic pain program, and we presented evidence that the average rate of reimbursement is much higher. (Provider)

conducted a study across a large sample of insurance carriers in 45 different chronic pain management programs looking at the reimbursement for 242 chronic pain patients seen by (Provider) from 1998 to the present. This research clearly established that the average rate of reimbursement for chronic pain programs in Texas is $105.00 per hour….An additional issue is (Carrier's) assertion that they are due a discount because of a PPO contract….(Provider) does not have a PPO contract with (Carrier) or (Audit Company) and no discount was given…."

2. Respondent: No Position Statement submitted.

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on 07/09/01 and extending through 08/17/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $14,737.50 for services rendered on the dates of service in dispute above. The Carrier paid Requestor $6,592.00. The amount remaining in dispute is $8,145.50.

4. The Carrier denied additional reimbursement as "646-CHARGE IN EXCESS OF UNIT VALUE OR REASONABLE ALLOWANCE; M: NO MAR; MSG: C EOS-MCS Inc. adjustment to charges based on AHN's contract with this provider; Negotiated contract price".

5. According to the documentation submitted, the Provider is a Non-CARF accredited facility. Therefore, the 20% reduction will apply, per MFG, MGR (II) (C), if reimbursement is warranted.

V. RATIONALE

Medical Review Division's rationale:

The Requestor has billed CPT code 97799-CP, which is DOP (no MAR) per the MFG. The MFG reimbursement requirements for DOP states, "An MAR is listed for each code excluding documentation of procedure (DOP) codes….HCPs shall bill their usual and customary charges. The insurance carrier will reimburse the lesser of the billed charge, or the MAR. CPT codes for which no reimbursement is listed (DOP) shall be reimbursed at the fair and reasonable rate."

Carrier's EOB denied the disputed charges as "C" and "M". The Carrier did not show evidence that the Provider was a contracted Provider. Therefore, the "C" denial is a moot point and this dispute will be reviewed as "Fair and Reasonable."

There is no Carrier response noted in the Commission's case file. Per rule 133.304 (i) "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the

Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

Medical documentation submitted indicates these charges are for a chronic pain program. The Medical Review Division has reviewed the file to determine which party has provided the most persuasive evidence of fair and reasonable. The Requestor has submitted a study of sample insurance carriers regarding what they have reimbursed for Chronic Pain. However, this study in itself is not sufficient to support that the provider's billed amount was fair and reasonable. The Requestor has also submitted additional reimbursement data, which are example EOBs for charges billed for similar services. The EOBs submitted were partially redacted and consequently cannot be utilized as evidence. Rule 133.307(G)(3)(E) states, "Prior to submission, any documentation that contains confidential information regarding a person other than the injured employee for that claim or a party in the dispute must be redacted by the party submitting the documentation, to protect the confidential information and the privacy of the individual. Un-redacted information or evidence shall not be considered in resolving the medical fee dispute."

Therefore, additional reimbursement is **not** recommended

The above Findings and Decision are hereby issued this 26th day of March 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd